Welcome to the Pennsylvania Dual Diagnosis Direct Support Curriculum training on *Autism Spectrum Disorder*, sometimes referred to as ASD.
The Commonwealth of Pennsylvania’s Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Developmental Programs (ODP) have undertaken a joint initiative to address the needs of people who have an intellectual disability as well as mental health challenges. People who have both of these challenges are commonly referred to as those who have Dual Diagnosis. For the purpose of this training, Dual Diagnosis is not referring to co-occurring mental health challenges and substance abuse or dependence, although people can have substance abuse or dependence issues as well as a Dual Diagnosis of an intellectual disability and a mental health challenge. The curriculum was designed for Direct Supporters, Supports Coordinators and others who work in either the intellectual disability field or the mental health field.

The ultimate goal of this training curriculum is to provide information that can aid in the understanding of the struggles and the triumphs of those you support or will support. This curriculum was designed to demonstrate the complexity of Dual Diagnosis and the factors that need to be considered to best support those with whom you come into contact. The PA Dual Diagnosis Direct Support Curriculum was also designed to demonstrate that all people in this world, regardless of their challenges, are much more alike than they are different.
• The information presented to you today is to increase your awareness. It is not intended to replace medical advice.

• If you believe you or someone you support has these conditions or concerns, please seek the advice of a physician.
By the end of this presentation, you will understand the core features of Autism Spectrum Disorder and how these core features impact social and emotional functioning. We will discuss what core features mean and identify what they are during the course of this presentation.

You will also learn some techniques to positively support someone who has an Autism Spectrum Disorder.
Autism Spectrum Disorder, or ASD, is a neurodevelopmental disorder. A neurodevelopmental disorder is an impairment of the growth and development of the brain or central nervous system. A narrower use of the term refers to a disorder of brain function that affects emotion, learning ability and memory which unfolds as the individual grows.

There are genetic alterations that have been found to contribute to being at risk for developing ASD.

Many genetic syndromes show strong correlations to ASD. For example, the leading genetic correlation to ASD is Fragile X Syndrome. Fragile X Syndrome generally impacts males more than females because males only have one X chromosome.

The statistics show that more boys are diagnosed with ASD than girls.

Individuals with ASD may or may not also have an intellectual disability.
Autism research is currently focusing on various neurological and genetic concerns listed above which have shown to be correlated with ASD. However, there is no ONE cause for ASD. Many different concerns and genetic issues have been found to be associated in the development of ASD. We will discuss seizures on the next slide.

In identical twins who share the exact same genetic code, if one has ASD, the other twin also has ASD in nearly 9 out of 10 cases. If one sibling has ASD, the other siblings have 35 times the normal risk of also developing the disorder. Researchers are starting to identify particular genes that may increase the risk for ASD. Still, scientists have only had some success in finding exactly which genes are involved.

Most people who develop ASD have no reported family history of autism, suggesting that random, rare, and possibly many gene mutations are likely to affect the person's risk. Any change to normal genetic information is called a mutation. Mutations can be inherited, but some arise for no reason. Mutations can be helpful, harmful, or have no effect.

Having increased genetic risk does not mean a child will definitely develop ASD. Many researchers are focusing on how various genes interact with each other and environmental factors to better understand how they increase the risk of this disorder.

A “soft sign” is a slight to very slight variation from the norm. Possible examples include a child who walks before crawling, mixed lateral dominance (for example, a person who kicks with their right foot, bats left handed, and throws right handed) difficulty in performing rapid alternating movement, and minor problems in balance.

Tuberous sclerosis is a rare genetic disorder that causes noncancerous tumors to grow in the brain and other vital organs. Tuberous sclerosis occurs in 1 to 4 percent of people with ASD. A genetic mutation causes tuberous sclerosis which has also been linked to intellectual disability, epilepsy, and many other physical and mental health problems. There is no cure for tuberous sclerosis, but many symptoms can be treated.
Individuals with ASD may also have some of the common medical concerns listed on this slide. Not everyone with ASD will have all or even some of these concerns, but they are worth noting. Intellectual and developmental disabilities do occur with ASD. However, individuals who have a diagnosis of high functioning ASD, formerly Pervasive Developmental Disorder and Asperger’s Syndrome, may also have extremely high to gifted intelligence. Many children with ASD have some degree of intellectual disability. Researchers have estimated that as many as 40% of people with intellectual disability meet the diagnostic criteria for ASD. When tested, some areas of ability may be normal, while others—especially cognitive (thinking) and language abilities—may be relatively weak. For example, a child with ASD may do well with tasks related to sight, such as putting a puzzle together, but may not do as well with language-based problem-solving tasks. Some children with ASD, such as those formerly diagnosed with Asperger’s syndrome, often have average or above-average language skills and do not show delays in cognitive ability or speech. Almost half, or about 44%, of children identified with ASD have average to above average intellectual ability.

One in four children with ASD has seizures, often starting either in early childhood or during the teen years. Seizures, caused by abnormal electrical activity in the brain, can result in a short-term loss of consciousness, or a blackout. Sometimes lack of sleep or a high fever can trigger a seizure. An electroencephalogram, or EEG, is a nonsurgical test that records electrical activity in the brain. An EEG can help confirm whether a child is having seizures. However, some children with ASD have abnormal EEGs even if they are not having seizures.

Seizures can be treated with medicines called anticonvulsants. Some seizure medicines affect behavior and changes in behavior should be closely watched in children with ASD. In most cases, a doctor will use the lowest dose of medicine that works for the child. Anticonvulsants usually reduce the number of seizures but may not prevent all of them.
• Allergic reactions, allergies and sensitivities are also reported in people with ASD. It is important that children and adults with ASD be monitored for allergic reactions. Allergy testing is recommended. Behavioral concerns associated with allergies have been reported and medical treatment and/or allergy management is vital in this situation.
• Parents of children with ASD report that their child has frequent gastrointestinal (or GI) or digestion problems, including stomach pain, diarrhea, constipation, acid reflux, vomiting, or bloating. Food allergies may also cause problems for children with ASD. If the individual you support with ASD has GI problems, a gastroenterologist, can help find the cause and suggest appropriate treatment.

• Some studies have reported that children with ASD seem to have GI symptoms. Some children with ASD can have difficulties tolerating different types of foods; for example, different textures, colors, or smells. Some children with ASD may have lactose intolerance, chronic constipation, or chronic diarrhea. The research suggests that some children with ASD may not have underlying GI problems, but that their rigid diet (for example exclusion of vegetables or fruit) may cause GI problems.

• Some parents may try to put their child on a special diet to control ASD or GI symptoms. While some children may benefit from limiting certain foods, there is no strong evidence that these special diets reduce ASD symptoms. If you want to try a special diet, first talk with a doctor or a nutrition expert to make sure your child's nutritional needs are being met.

• Individuals with ASD tend to have problems falling asleep or staying asleep, or have other sleep problems. These problems make it harder for them to pay attention, reduce their ability to function, and can lead to behavioral challenges. In addition, parents of children with ASD and sleep problems, tend to report greater family stress and poorer overall health among themselves.
Individuals with ASD may either over-react or under-react to certain sights, sounds, smells, textures, and tastes. For example, some may dislike or show discomfort from a light touch or the feeling of clothes on their skin. Some may experience pain from certain sounds, like a vacuum cleaner, a ringing telephone, or a sudden storm. This may result in someone covering their ears and screaming. Some people may have no reaction to intense cold, heat or pain.

Researchers are trying to determine if these unusual reactions are related to differences in integrating multiple types of information from the senses.
The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition is also known as the DSM-5. The DSM-5 grouped several disorders and syndromes from the previous DSM (DSM-IV-TR) and placed them in a new diagnostic category known simply as Autism Spectrum Disorder. For the purpose of recognizing these disorders and diagnoses, brief information on these historical DSM diagnoses will be provided on the next slide.
The DSM-IV-TR had several disorders which have now been grouped into the ASD category in the DSM 5. These disorders include:

- Asperger syndrome, which was frequently diagnosed in individuals at early adolescence; these individuals often did not have an intellectual disability. Their educational abilities were normal or perhaps even gifted. As these individuals became older, others around them started to notice their unique socialization methods which may have included some or all of the following:
  - There was no significant language or cognitive delay
  - There was precocious speech – people were like a “little professor” in their area of interest
  - There was a fascination with letters and numbers
  - There was attachment to family but not to others
  - People were interested in others but had no idea how to establish relationships

- Another disorder in the DSM-IV-TR that has now been grouped into the ASD category is Pervasive Developmental Disorder Not Otherwise Specified or PDD-NOS. This was considered mild compared to traditional autism. However in 2-5 percent of cases, individuals who have PDD-NOS can regress into a state of having impairments more often seen in classical autism. Regression means that a person was showing age appropriate developmental milestones but then
began losing skills that they had previously obtained.

- Childhood Disintegrative Disorder also known as Heller syndrome, is very rare with no known cause. Children with this disorder generally demonstrate normal development up until 3 to 4 years of age followed by a dramatic decline in social, communication and motor skills. Again, this was listed as a disorder in the DSM-IV-TR but now is grouped into the ASD category in the DSM-5.
The Centers for Disease Control and Prevention, or the CDC, estimates that 1 in every 68 children born is diagnosed with ASD.

- Of these statistics, it has been found that 1 in every 42 boys and 1 in every 189 girls is diagnosed with an ASD in the United States.

- Centers for Disease Control & Prevention, 2017

- The Centers for Disease Control and Prevention, or the CDC, estimates that 1 in every 68 children born is diagnosed with an ASD. Because of the ever-increasing number of individuals being diagnosed with ASD, training and understanding of ASD has become more and more vital to both the intellectual disability and mental health systems as well as society as a whole.
According to the DSM 5, ASD is diagnosed based on two main or “core” features. The first core feature is qualitative impairment in communication and/or social interactions. Qualitative impairment means that there is a significant impairment in communication skills and social interaction skills that cause noticeable difficulty for the individual throughout their lifespan. These impairments are severe and pervasive. The second core feature is restrictive, repetitive, and stereotyped behaviors.

During the course of this training, we will talk more specifically about each of these core features and how they relate to ASD. Individuals who have a diagnosis of ASD will have individual differences. No two individuals with ASD are the same.
Infants are born wired for social interaction. From the first days of life, the human voice and face is of great interest to the child. Babies engage with the adults around them by crying or squealing to get assistance and communicate what they need. Brain development is observed by parents from birth onwards.

Take a moment to think about any interactions you’ve had with your own child as an infant or someone else’s newborn baby. Think about the infant’s behaviors. Think about what kinds of things you’ve done to interact with the infant. Think about what the infant’s response was to these actions.
Some parents have concerns in the first year of their child’s life. Parents may notice that their child does not look at them or make eye contact with them. Parents may notice a lack of response in their child to their facial expressions such as laughing or smiling. The child also may not cry, even when hungry. By the second year, some parents may also report additional concerns, but may believe the concerns are associated to a physical problem. For example, many parents report that they first believed that their child may be deaf or had some form of hearing impairment due to the child’s failure to respond when their name is called. By the second year, most parents will also report that they do not feel that their child interacts and plays similarly to their peers. Language delays can become apparent at this time as well. These can include limited to no verbal communication.
There are several issues that are present which hinder normal social development. Children and adults with ASD may demonstrate difficulties with social interaction due to the following issues.

**Selective Attention** means that children and adults with ASD will generally focus strongly on particular desired stimuli and ignore stimuli that they are not interested in.

**Social Engagement Issues** mean that children and adults with ASD tend to have difficulty engaging in social interactions such as imaginary play with other children or engage in conversations with other adults. An individual with ASD may be misperceived by others as a “loner” who does not seek out relationships or seem interested in interacting with others. This concern is often misperceived by others as simply the individual’s personality or desired preference when, in fact, it can often be due to communication deficits.

**Social Reciprocity Issues** mean that children and adults with ASD can have a lessened ability to comprehend the “give and take” in social relationships. For example: If you say “Hi, how are you today?”, a person with an autism spectrum disorder may say, “good” but not recognize the notion of being courteous and asking how YOU are doing. Lack of social reciprocity may also be seen in play situations in children. For example, a child with ASD may have expectations that others will play what they want to play and how they want to play it. Individuals with ASD may also become agitated if others voice their opinion in wanting to play or do something else. The individual may become aggressive or self-injurious if others do not follow their lead in play or other activities. This can sometimes reach the point where the person with autism may demand that others play in the same recurring roles during play and will become agitated if a peer or supporter wishes not to take on that role. At certain points, these demands can become so ritualized
that the person with ASD does not find enjoyment in the activity because others involved are “not doing it right”. Sometimes issues with social reciprocity can lead to later significant behavioral challenges if they are unsupported or untreated.
This slide refers to three additional issues that may lead to difficulties with social interaction for those with ASD. These include **attachment concerns** – meaning that children with ASD may or may not seek affection or attention from parents, siblings or other caregivers. **Social-communication deficits** will be discussed more in depth later in this training. And **relationship development problems** which stem from issues regarding social engagement and social reciprocity issues.
• Individuals with an ASD are three times less likely to make eye contact compared to people without ASD. A person who has ASD who does not make eye contact may not have better or worse social skills than other individuals with ASD who do make eye contact.

• However, object fixations do predict decreased social competence. This means that people who have ASD who tend to focus on objects such as the wheels on a toy car or twirling string or any other part of an object will most likely have a more decreased social competence than peers who do not become very fixated on objects.
Empathy is the ability to understand how other people think and feel. Demonstrating empathy is sometimes problematic for individuals with ASD. They may notice other people’s behavior but may have difficulty relating to the other person’s feelings. Difficulties with social reciprocity and empathy may isolate the person from developing deep meaningful connections with others. Without empathy and social reciprocity, others may feel that the individual with ASD is insensitive to other people’s feelings or that they simply do not care about how the other person feels about the other feels. This is not true. It is not that the person with ASD understands the feelings of others and chooses to ignore them, they may simply just not understand how other people feel. This also becomes more confusing as many individuals with ASD can recognize emotions but they may not recognize when another person’s emotions change or understand why a person’s emotions have changed.

For example, a 22 year old man who has ASD was excitedly asked by his 11 year old brother if he was coming to his birthday party. The older brother stated “No”. This obviously upset the 11 year old brother who felt that his older brother did not care about him enough to come to his birthday party. The younger brother began to cry. The older brother looked at his younger brother and asked him why he was crying. This angered the 11 year old brother who then said “You know why I am crying you jerk! “ This angered the older brother who then began cursing at his younger brother. When their mother yelled at him for cursing at his younger brother, the older brother began to hit himself on the head.

In this example, we can see some of the social interaction and communication issues associated with ASD. Problems understanding what another person means such as their intentions, thoughts, or beliefs. Additionally, the mutual intent of the conversation as well as reading and understanding another person’s body language or emotions can be difficult for a person with ASD.
• The last example shows just one of many situations where, when family members or caregivers do not understand the challenges associated with ASD, and both the person who has ASD and those who care for them can suffer. By educating both the younger brother and the man’s mother, they learned that the man’s response to certain questions was not meant to be insensitive or uncaring, but rather just part of his disability. It also helped the family better understand the frustrations that the man would have when placed in these difficult situations. The man and the family benefitted greatly from what is known as social coaching.

• Social coaching refers to the teaching of social skills. Individuals with ASD require ongoing and continuous teaching of social skills in a proactive, not reactive way. This means that social skills are best learned consistently and in the moment and not just as a “review” of how the person did not act socially appropriate. The best way to socially coach an individual is to act as the “translator” during a social interaction. Sometimes we, as supporters, need to help the person with ASD understand what is really happening in a social interaction and what a person’s responses might really mean. For individuals with ASD, emotions may be understood in isolation but not in the moment.

• Going back to the example of the man and his brother, a person who was working with the man using social coaching would have said to the man... “Your brother is asking if you would like to come to his birthday party. He smiles and giggles mean that he is excited and he really wants you to come and be at the party with him.” This kind of coaching then helps “fill in the gap” to help the person with ASD understand what is occurring during this social interaction. With social coaching, the man was then able to understand and agreed to attend the party. The man did not realize how important his agreement to go to the party was for his brother. He thought is was just a simple yes or no question.
Sometimes individuals with ASD may have a strong interest in facts. They may talk about a very specific interest and know everything about a particular subject. For example, an individual with ASD may know lots of information about the weather or animals. Why the interest in facts? The answer is because facts do not easily change. There is usually little emotion and less intuitive information that is needed when talking about facts. Facts are much more “black and white”. Human emotions and human interactions are filled with a lot of “gray areas” which is why many individuals who have ASD incorporate facts into their conversations with others.

For example: You are driving down the road when you see a man in your rearview mirror driving erratically. He is “riding your bumper” and honking. He then moves to the other lane and quickly cuts you off and you drive off to the shoulder of the road. You are probably scared and/or angry, so you decide to follow this man to tell him his behavior is inappropriate. You see him pull up to a hospital and, in the back of his car, you see that his wife is in labor. You suddenly understand why the man was in such a rush and you empathize with his behavior. Even though we know the “rules of the road”, many of us can understand why this man was “breaking the rules”. A person who has ASD may not understand that there can be exceptions to every rule.

When it comes to concepts, rather than facts, it is much more difficult for an individual with ASD to understand. The more abstract the concept, the more difficulty a person with ASD may have with it. For an individual with ASD, the creation of rules is important as it is their way of understanding the world. These rules or “codes” or “laws” can sometimes be very rigid and leave little room for any situations that may be an exception to their rules. Because of this, some individuals who have ASD may appear very rigid, disagreeable, and non-compliant to the rules of an agency, a home, or society.

Something abstract is a general idea derived or inferred from specific instances or occurrences. Some abstract examples include: the idea of “true love”, morality, or
ethics. People are very complex and so are the rules of society. Our sense of morality can change. Complex social situations are very difficult for those with ASD to understand. Facts make sense, while social interactions, which may have many variables, do not.
Because of social skill deficits, people who have ASD can appear to be:
- Oppositional/defiant
- Uncaring/unemotional
- Manipulative
- As if trying to challenge staff by refusing or correcting them
- A challenge to authority
- Look like they “should know better”

These social interaction concerns are a part of the ASD, **NOT a part of the person’s personality or attitude.**
Impairment in communication is part of one of the two core features of ASD. Thirty percent of children with ASD remain minimally verbal. About 25–30% will be nonverbal, or only minimally verbal by the time they enter kindergarten. The distinction between preverbal and nonverbal may be significant but at this point is difficult to determine.

There are other communication issues that can also be present. Some examples of these include echolalia. Echolalia is the repeating of words or vocalizations of another person. It is utilized as a way in which to “hold on” to what someone has just said in order to attempt to cognitively process a response. When you continue speaking, or ask another question, this may re-start the cycle. It is not that the person does not understand what you are saying or simply wants to mimic you, they are trying very hard to think of a response. Give someone an extended period of time to respond to you before interrupting this process.

People with ASD may use pronoun reversal. This occurs when children refer to themselves as "he," "she," or "you," or by their own proper names. Pronoun reversal is closely linked to echolalia. Since children with ASD often use echolalic speech, they refer to themselves as they had heard others speak of them and misapply pronouns. Here is an example: a parent may say to their child, “Are you having a good time?“ The child with ASD may respond: “You sure are.”

Monotone voice involves speaking in the same tone of voice with little to no emotion. A person displaying a monotone voice can be very difficult to understand in regards to their current emotions as emotional affect is often absent or limited to extreme situations.
Prosody is the use of tone of voice in speech. An example of prosody is the way in which we would say things such as: *You’re coming with me.* versus *You’re coming with me?* The way in which we use our tone conveys either a command or a question. When a person has difficulty recognizing and also utilizing prosody, you can see how social situations can become anxiety producing or can elicit anger.
People with ASD can have problems following the rules of conversations and storytelling. Problems can include the use of language, for example, greetings such as hello and goodbye. Other problems include informing, for example, “I’m going to get a cookie”; demanding, for example, “Give me a cookie”; promising, for example, “I’m going to get you a cookie”; and requesting, for example, “I would like a cookie, please”.

People with ASD can struggle to change language appropriately. Examples include: talking differently to a baby than to an adult; giving background information to an unfamiliar listener; and speaking differently in a classroom than on a playground.
Because of various social interaction and communication concerns, many individuals with ASD are seen as: treatment resistant, challenging, having a mental health challenge, or just plain difficult or “bad”. This is not the case. Understanding the communication deficits of each person you support may help you to better support the person more effectively.

- Deficit in communication highly correlates with challenging behavior
- What the person says may not be what they mean
- Don’t know how to describe what’s wrong
- May repeat a phrase that has worked in the past
Now we will talk about the second core feature of ASD.

Restrictive, Repetitive and stereotyped behaviors, also known as RRBs, are an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in intensity or focus. They are an apparently inflexible adherence to specific, nonfunctional routines or rituals. Simply put, it is a desire or need for “sameness” - the same routine, ritual, or schedule. Examples of stereotyped and repetitive motor mannerisms include: hand or finger flapping or twisting, complex whole-body movements, and a persistent preoccupation with parts of objects. Engaging in RRBs does not automatically mean that the person also has an Obsessive Compulsive Disorder or OCD.

An example would be an individual who is considered “obsessed” with something such as: numbers, transportation routes, a particular game, toy, activity, movie, TV show, topic such as biology, astronomy, or the weather, and any other interest in which is usually the main topic of the individual’s conversation. Again, this does not necessarily mean the person has OCD.

Ritualistic behavior in ASD is clinically differentiated from OCD. Some rituals can become so complex that it may appear to be related to OCD. Thorough and vigorous assessment is needed in order to determine whether or not the person meets the criteria for OCD.

Repetitive motor mannerisms such as: rubbing of the head, touching of the nose,
“tonguing” the inside of the cheek and other nonverbal mannerisms that are utilized as a person’s own distinct habit. These actions are often considered to be not reliable indicators of OCD in the ASD population.

- An example of such behavior would be a person focusing on twirling a straw over and over again.
• RRBs can be utilized as a coping mechanism to manage nervousness or stress. RRBs can increase in intensity and severity the more nervous or stressed a person becomes. Examples of such behaviors are: rocking, pacing, hand-flapping, and self-injurious behaviors. Assessment for anxiety disorders from a psychiatrist is vital and completing a Functional Behavior Assessment to see when the RRBs occur and do not occur is also vital. Finding more appropriate ways to engage in fascination or interest is also important if the RRB places the person at risk to hurt themselves or others. We will discuss Functional Behavior Assessment as well as Anxiety Disorders in other curriculum modules.

• Here are some examples of behaviors or RRBs we habitually do when we are anxious: smoking, nail-biting, foot tapping, pen chewing, knuckle cracking, and eye rubbing. Just because we engage in such behaviors does not automatically mean we meet the criteria for an anxiety or obsessive-compulsive disorder. We may engage in these actions because we are nervous but not to a degree that clinical intervention and treatment is needed.

• The important difference between RRBs and OCD is the function or reason why someone is engaging in a particular behavior. RRBs can be utilized to de-stress, as a relaxation strategy, or as a habitual behavior in order to occupy themselves. People with OCD engage in ritualistic behaviors to control the environment and to avoid bad things from occurring. RRBs are things people may LIKE to do, whereas compulsions are something a person with OCD feels that they HAVE to do.
When supporting individuals with ASD social coaching is important to teach the person the “shades of grey” in a social interaction. Because of a lack of social interaction skills, people with ASD are sometimes labeled as “weird”, “odd”, “bizarre”, “dorky”, or “creepy” by their peers who do not understand ASD. They may be bullied and taken advantage of. They may also be victims of physical or sexual assault. People with ASD usually have little or no sex education. This can result in an individual with ASD saying inappropriate sexual comments which can lead to police involvement. This can also result in the individual with ASD being sexually or physically assaulted.

If the individual has a very narrow interest of things that they enjoy and are around peers who do not share their interest, this can frustrate their peers and further isolate the individual with ASD from social interactions. All these factors play into the importance of social coaching and educating others about ASD.
Depression and anxiety have been found to be the most common co-morbid psychiatric conditions with Autism Spectrum Disorder. Clinically impairing anxiety affects approximately 44% of children and adolescents with ASD. Studies have shown greater rates of anxiety and depression in those with ASD.

Depression and anxiety symptoms typically increase in adolescence. All adolescents can feel moody or left out, but young adults with ASD really are. Depression and anxiety symptoms appear to be triggered by life experiences and increasing self-awareness as well as recognizing the differences in their lives compared to their non-ASD peers. Suicidal thoughts can be observed as really scary and/or detailed threats. It is important that those who support people with ASD recognize that those they support need to feel good about something - remind them what they are good at and comment on it.

Involving individuals with ASD in social groups and activities from a young age is crucial to enhance socialization abilities and reduce feelings of isolation and potential depression as well as anxiety symptoms in the future. Sometimes just being in the presence of others can make us feel less lonely, even if we are not directly interacting with people.
Take a moment to think about the following questions:

- Have you ever spent time with a friend or loved one and you didn’t interact with them?
- Can you feel close to someone without speaking?
- Can you feel more safe and secure just knowing someone is present with you even if you are not interacting?
Some of the possible signs of depression in the ASD population include, but are not limited to:

- Isolating more than usual
- Talking about people who have passed away
- Decreased interest in preferred activities and daily self-stimulating behaviors
- Loss of skills
- Change in presentation of a perseveration (increases/decreases)
- Increased agitation/irritability
- Spontaneous crying episodes
- Increase in self-injury/self-mutilation
- Suicidal ideation
- Decreased smiling/increased whining
- Sleep disturbances
- Perseveration of videos/movies with dangerous acts or violent/suicidal imagery
- Talking about feeling worthless/hopeless
### Supporting an Individual with Depression/Anxiety Issues

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<td>• Help reduce social limitations</td>
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- It is extremely important that those supporting people who have ASD really KNOW the individual they are supporting. Knowing an individual’s baseline is vital to recognizing whether or not there may be a medical and/or psychiatric issue later down the road.

- If a person is currently prescribed psychotropic medications, it is very important for supporters to track the effectiveness of the medications for the prescribing doctor. Are the person’s symptoms reducing? Increasing? Remaining the same?

- Counseling and psychotherapy can also be beneficial. Sometimes traditional counseling is effective and sometimes a counselor or therapist that has expertise in ASD may be needed.

- Future plans create an atmosphere of hope. It is always important to at least let the person know they are not alone and that you are there to support them in their future endeavors.
When supporting someone with ASD, the first question is: what is the person’s baseline behavior? Baseline behavior is how the person usually acted and reacted in regards to their environment throughout their life? Is the observed behavior new or old? Has this behavior been seen in this person before? Does the behavior “come and go”?

The really important question for supporters is whether or not the challenging behavior is new or is this behavior historical and is now a problem because the person has become bigger, faster and stronger as they are now adults?

Historical information is key to understanding and recognizing changes to a person’s baseline behavior. It is important to constantly assess for changes from the baseline behavior. And it is vital to rule out any medical reasons for changes from baseline. Baseline behavior can be assessed in the long-term and short-term depending upon the challenging behaviors and/or medical and psychiatric factors.
Remember ASD is a neurodevelopmental disability. It is important that every person’s supports are individualized to their specific challenges and strengths. Teaching the individual specific strategies such as:

- Coping
- Relaxation
- Asking for assistance/break
- Learning to deal with disappointment
- Problem-solving
- Socialization skills - social coaching

Remember, it is recommended that social coaching is done in the moment and in the environment.

Also remember that a person who is diagnosed with ASD may never become fully comfortable socially, but they can learn behaviors that can help them function better socially.
When supporting someone with ASD, use simple language: be clear, concrete, and concise. It is also important to point out linkages and show cause and effect. This goes back again to our example of the man and his brother’s birthday. By explaining why his brother got upset, it allowed the man to make the connection between what he said and why his brother reacted the way he did.

Don’t assume that those you support simply just understand why YOU say and do the things YOU do. Always explain yourself and walk the person through your own thoughts and emotions so they can understand why YOU say and do the things.

Relate information to other subjects. Sometimes the best teaching tool is utilizing something the person you support is very interested in and applying it to learning something new. For example, there was a man who was obsessed with the weather. He loved following storms and watching the weather channel. He loved predicting storms and telling people all about it. His supporters were able to utilize his love of weather to teach him about emotions and predicting how people may react. So, when the man was sad, he would say “I feel cloudy”. If he was happy, he would say “I feel sunny”. If he was discussing things he wanted to tell people, his supporters would discuss it like predicting the weather. For example he may say “If I tell my roommate to shut-up, there is a 85% chance of a stormy situation!”. Using a person’s interests to teach other skills can be invaluable.

Tell people why this is important to “real life”. Explain anything abstract. Check for understanding and don’t demand multi-tasking.
When a person with ASD is upset, it is important to remember the person may regress and lose listening and/or speech skills.

If this occurs it may be best to write a note or draw a picture instead of speaking to them. Hand it to the person or place it in their visual range.

Also when upset, the person may rock or self-stimulate. If this occurs limit people from the area to reduce stimulation. Limit talk and don’t touch. Allow the person time to calm down.
When supporting someone with ASD, it is important to check for understanding. A person may perceive what you said differently. It is important to get feedback from the person so that they do not perseverate or misunderstand what you have said or done in a negative way. People with ASD may check that they are understanding you by repeating questions rather than asking for you to better explain. If this occurs, be clear, be concrete and be concise. Simplify your explanation or use visual cues along with your verbal direction.
• No two people who have a diagnosis of ASD are the same even if they share common characteristics.
• Many sensory concerns reported lessen in adulthood. However, supporting an individual with ASD may mean that the person needs individualized communication assessments, sensory assessments, medical assessments, adaptive equipment, and individualized supports based upon other co-occurring factors such as intellectual disability, psychiatric problems and medical problems.
When supporting someone with ASD who also has behavioral challenges, it is important that we recognize and continually reassess how an individual is progressing in relation to challenging behaviors. Look and evaluate programmatic issues such as correlations to challenging behaviors and people, places and things. Make environmental and adaptive changes to enhance overall well-being for the person. These changes can be based upon information provided by the team in the Functional Behavioral Assessment if the person receives one.

Functional Behavioral Assessments are discussed more in depth in the Functional Behavior Assessment and Behavior Support Planning training module of the Dual Diagnosis Direct Support Curriculum.
Be mindful of your own communication styles, nonverbal behaviors, tone of voice and use of words, phrases and comments that might be confusing.

- Think before you speak. Think to yourself: *How can what I am about to say be misperceived in a bad way?*
- Respect the person.
- Recognize the possible need for the person to engage in restrictive repetitive and stereotyped behaviors (RRBs) to deal with stress/nervousness.
- Document/communicate as much information about a person’s behaviors, scripts, communication styles, language to all attending physicians.
One of the best ways to summarize ASD is the “Foreign Exchange Student” exercise. Due to the communication concerns and deficits seen most often in ASD, it can be perceived as though individuals with ASD sometimes are unaware of our methods and forms of communication. For example: If you were a foreign exchange student in another country, what things would you have to learn in order to succeed in living in that country? Of course you would want to learn the language but you would also need to learn the “Do’s and Don’ts” of that culture. What is acceptable or unacceptable? How would you ask for directions? How would you get information from people if you did not fully understand the language? If you are a person that immigrated to this country, what are some things that you learned by experience living here in America? What are some things that may have been acceptable or unacceptable in your country that are different here in America?

Many people with ASD learn social and communication skills better when they are approached in this way. Assume the person may be unfamiliar with how Americans interact with one another. Assume that the person with ASD might not understand our greetings and non-verbal behaviors. Assume that all of the little nuances of communication in our culture that we picked up on our own over the years have not necessarily been as easily understood by a person with ASD. When you approach teaching social and communication skills, without assuming the person simply “just or should already know it”, you can make a bigger impact.
• Every person with ASD has their own unique personality, just like the rest of us. No two people with ASD are exactly the same. Treat those you support as the individual they are. Get to know them and you will discover how truly special that they really are.
Congratulations, you have successfully completed the Dual Diagnosis Direct Support Curriculum training on

*Autism Spectrum Disorder (ASD)*

Congratulations, you have successfully completed the *Autism Spectrum Disorder* training.
Thank you for your participation.